DOCUMENT RESUME

ED 159 571 CG 012 853

AUTHOR Baldwin, Bruce A.
TITLE Styles of Crisis Intervention: Toward a Convergent Model.
PUB DATE 18 Mar 78
NOTE 21p.; Paper presented at the Annual Convention of the Southeastern Psychological Association (24th, Atlanta, Georgia, March 15-18, 1978); Not available in hard copy due to marginal legibility

EDRS PRICE MF-$0.83 Plus Postage. PC Not Available from EDRS.
DESCRIPTORS Adjustment Problems; *Counseling; *Crisis Therapy; Helping Relationship; *Intervention; Mental Health Programs; Models; Problem Solving; *Psychiatric Services; *Psychotherapy
IDENTIFIERS *Crisis Intervention

ABSTRACT

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Styles of Crisis Intervention: Toward a Convergent Model*

Bruce A. Baldwin

University of North Carolina

School of Medicine

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Running head: Styles of Crisis Intervention

*Presented at the Twenty-Fourth Annual Meeting of the Southeastern Psychological Association, Atlanta, GA. March 15-18, 1978.

CG012853

Abstract

Crisis intervention is a now accepted form of brief therapy that has become the treatment of choice for many individuals seeking to cope more effectively with life stresses. Recently, there has been an evolution of several disparate styles of crisis intervention in the direction of one convergent model. The screening/assessment style of crisis intervention with roots in the medical model and the problem-solving style that originated in the alternate services are now converging. This evolution reflects a more uniformly accepted framework of concepts and principles on which to base the practice of crisis intervention.

Styles of Crisis Intervention:

Toward a Convergent Model

It is unfortunate that with more use of crisis intervention in the last decade the meaning of this model, and the principles on which it is based, have become increasingly generic. This model remains ill-defined and diffuse at the practitioner level and there are many myths and misconceptions associated with it (Baldwin, 1977). Conversely, it has become an approach of greater professional interest to therapists (and paraprofessional counselors) who are further developing this model at both theoretical and applied levels.

When the clinical practices of both professional and paraprofessional crisis therapists are examined, it is apparent that there are several "styles" of crisis intervention now used that are quite distinct. These divergent styles reflect the training of their respective practitioners and the particular philosophy of change on which each of these approaches is based. These contrasting styles have contributed to crisis theory by defining the intervention process from differing theoretical and philosophical frameworks. These different styles have also highlighted some of the strengths and weaknesses inherent to each.

In recent years, there has been a trend toward convergence of different styles of crisis intervention. Of particular interest is the convergence of the approaches to crisis intervention represented by the professional practitioner and that of the paraprofessionally-staffed alternate services. This convergence has resulted in a more unified and accepted conceptual framework for crisis intervention that is usable at both levels of training. At least part of this convergence has resulted from the rising prominence of community psychology and the increased sophistication of community mental health pro-

grams. Crisis intervention represents an increasingly important interface between the principles of community mental health and the practice of psychotherapy (Silverman, 1977).

Two Divergent Models

Although there are various "styles" of crisis intervention now in use, two models that represent polar extremes are discussed to provide perspective on the convergence phenomenon. The screening/assessment model and the problem-solving model reflect contrasting approaches to client crises at both the theory and practice levels. An overview of the defining characteristics of each of these disparate approaches to crisis intervention is presented in Table 1.

The Screening/Assessment Model. The screening/assessment style of crisis intervention derives from the medical model as it is interpreted within a psychotherapeutic context. The medical model emphasizes treatment of an underlying disease process within the individual. As a result of this treatment philosophy, the screening/assessment model stresses thorough evaluation of the client through a rather comprehensive diagnostic process. The client, although experiencing an emotional crisis that reflects a present problematic situation that has produced stress, is seen to have underlying problems that have only become manifest in that situation. As Blaney (1975), discussing the medical model in terms of psychotherapy, states: "The visible evidences of the disorder are but manifestations of an underlying condition (not necessarily organic). This claim employs a direct analogy from physical illnesses, and dynamic psychiatry has accepted it with a vengeance" (p. 911).

In this model of crisis intervention, structure is created primarily by the therapist to accomplish an in-depth evaluation of the client with atten-

tion to the client's past experiences and psychodyanamics, family and social history, and medical background. Following this evaluation, the client is then referred as appropriate to other services or community resources for treatment. In those instances when the client presents with a medical and/or psychiatric emergency, available resources for effective treatment are mobilized immediately. At times, during and after an emergency intervention process, the therapist may also function as a coordinator of services required by the client (Baldwin, 1978). However, the primary task of the therapist when this style of crisis intervention is used is to evaluate the client's past and present functioning and to help the client to obtain appropriate treatment.

Because of the emphasis on screening and assessment, little therapy is provided when this model is used. Support is given during the evaluation process and any insight developed may be helpful to the client. However, the emphasis is on diagnostic evaluation and treatment is secondary to this process. The time-limited nature of the evaluation process (usually 1-2 therapy hours) also places severe limitations on treatment possibilities. At times, clients feel that their presenting problems are not addressed as the focus in the therapeutic contact tends to remain on exploration of the past. Because of this, many clients do not follow through with referrals initiated by therapists using a screening/assessment style of crisis intervention.

The screening/assessment model of crisis intervention is a viable form of therapeutic contact that is necessary for certain clients, particularly those with deep-seated or chronic problems. It is also an often mandated style of intervention due to clinic policies that limit service primarily to evaluation and referral. This is frequently the case in walk-in services or

in hospital emergency rooms. However, while necessary in certain cases, the screening/assessment model is an incomplete form of crisis intervention and must not be confused with crisis intervention as practiced by the skilled crisis therapist. In several important respects, the screening/assessment model of crisis intervention is more related to walk-in intake interviewing as practiced in professionally-staffed clinics than to crisis intervention even though such services are often called "crisis clinics."

The Problem-Solving Model. The problem-solving model of crisis intervention was standard in the alternate services that developed during the last decade. This model stands in contrast to the screening/assessment approach to emotional crises. The problem-solving model had its origins during the sixties when the rise of the counterculture signaled emergent lifestyles and a challenge to traditional values. Influential in the development of alternate services were questions about the ability (or willingness!) of mental health professionals to help youth involved in this subculture. There were also serious questions about the responsiveness of established service delivery systems to the special problems of youth at this time.

Clark and Jaffe (1972) discuss the rise of the counter-institution as the result of professionals attempting to "help" youth by seeking to modify their behavior to correspond to the normative values of society. The result was development of distrust between youth and mental health professionals. Yet, there were casualties of the counterculture that required intervention to deal with alienation, drug crises, and the adjustment problems associated with new lifestyles and values. A direct result was the development of alternate services (Baldwin, 1975) that functioned outside established mental health service delivery systems in the community.

These alternate services experimented with new styles of crisis intervention and with innovative service delivery systems. One significant innovation in these services was use of peer counseling as a primary service modality. Youth were trained in basic helping skills to help other youth experiencing crises. Training usually emphasized a humanistically-oriented, client-centered approach that stressed active listening, establishing an empathic relationship with the client, and information dissemination. A problem-solving approach was used in which a peer counselor helped clients to define and evaluate different courses of action as a response to a problem, to decide to act on one of them, and then follow through with the decision. Because of the client-centered emphasis in training, little attention was given to the need for the counselor to structure the counseling contact. Any structure created in the counseling interaction (e.g., problem-definition, goals, time commitment, etc.) was usually at the client's initiative.

The service delivery system in the alternate services also tended to de-emphasize structure. When responding to clients' problems via telephone "hot-lines" or as walk-in contacts, no appointments were needed and the counseling contacts were typically left open-ended. The client could call or return for additional counseling as often as needed for as long as needed. This type of service delivery provided immediate accessibility by consumers and complemented youth culture values.

The basis for crisis intervention in the alternate services was present problem-solving to help clients to adjust to the current realities of their lives. The relevance of past experience and of the psychodynamics that affected present functioning was frequently denied. As a consequence, the evaluation of psychodynamic aspects of clients' problems was ignored in lieu

of response only to the immediate problem of concern as defined by the client.

Deemed important was the "here and now" rather than the past, and "categorizing" clients into psychiatric diagnoses was considered to be "dehumanizing" and to be avoided. This present problem-solving emphasis (and the denial of the relevance of past experience and psychodynamics) was a direct reaction to the underlying disease process assumption of the medical model that was associated at the time (sometimes unfairly!) with mental health professionals. Also rejected in the alternate services was the assumption that long-term treatment was required for most clients to better adjust to their present realities.

This problem-solving style of crisis intervention was not without its problems. By responding only to a client's present problem, many times the underlying determinants of the client's difficulties were not perceived and an opportunity to resolve the crisis at a deeper level was missed. Indeed, some aspects of the highly client-centered approach used in the alternate services was counterproductive. The unwillingness (supported by absence of necessary training) of peer counselors to structure and focus the counseling contact frequently permitted the helping process to become quite diffuse. Client dependency was often encouraged (directly or indirectly) by over-nurturant peer counselors. Excessive client support, without concurrent encouragement of client responsibility for growth, tended to subtly reinforce client regression instead of adaptive coping in response to a problematic situation.

Another factor that compounded these problems was that the humanistic philosophy in these services was often distorted into an assumption that complete client acceptance by the counselor was somehow inherently therapeutic. Imposition of any structure in the helping relationship by a counselor was equated with lack of acceptance and excessive counselor control. As one

consequence, young and often idealistic peer counselors became over-involved in the helping process and were at times manipulated and used inappropriately by their clients (Torop & Torop, 1972). This led in turn to disillusionment and high drop-out rates (or staff burn-out) in the alternate services (Freudenberger, 1975).

Toward Convergence

A convergent model of crisis intervention has become evident in recent years. This model optimizes the strengths of both the screening/assessment and problem-solving approaches, yet minimizes the weaknesses of each respectively. Perhaps the best conceptualization of the convergent model of crisis intervention stems from the work of Gerald Caplan (1974) who has been instrumental in the development of crisis theory for more than three decades.

Crisis intervention using the convergent (Caplan-based) model has a past-present-future orientation. There is selective attention to reactivated conflicts from the client's past experience, the precipitant of the crisis (Hoffman & Remmel, 1975), as represented in the stressful situation now being experienced. Data, either past or present, that are not directly related to the client's present crisis have no place in the crisis intervention process (Morley, Messick & Aguilera, 1967).

There is also a future preventive emphasis in use of this model based on the assumption that a present problem situation can be used to work through a reactivated conflict from the past (i.e., the precipitant) that has in part determined the client's crisis. By by defining and working through the precipitant with selective attention to psychodynamics and learning more adaptive ways to respond to a present stressful situation (i.e., problem-solving), the probability of future similar crises is greatly reduced.

This time orientation also has implications for the crisis assessment process. While a more traditional diagnostic evaluation is not usually part of crisis intervention, there is assessment of all dimensions of the client's present crisis situation. The crisis intervention process by definition focuses on the client's stress, while in other forms of brief (and long-term) therapy, the emphasis is on the person (Stuard & Mackey, 1977). Butcher and Maudel (1976) seriously question the efficacy and relevance of traditional assessment procedures in crisis intervention as it may distract the therapist's attention away from the present crisis and ways to resolve it.

Further, the self-limiting nature of most emotional crises permits a time frame of approximately one to eight therapy hours for the crisis resolution process. These hours are structured and focused through a collaborative effort of both client and therapist. During the crisis assessment process, there is mutual definition of the problem, specific goals to be reached for crisis resolution, an an agreement on a period of time to work toward these goals.

This contracting process allows Parkinson's Law (i.e., work expands to the time alotted for its completion) in psychotherapy to become operational in a positive way. Client motivation for change is enhanced by defining in advance an end point and a time frame within which the client assumes major responsibility for the crisis resolution process. Further, use of time-goal contracts in crisis intervention helps to prevent regression, a therapeutic plateau, or excessive dependency from developing. Time and goal contracting helps maintain the focal emphasis on present stress that is the cornerstone of this model for crisis intervention.

Diffusion of the crisis intervention process is the result when effective time-goal contracts are not defined with the client early in the crisis resolu-

tion process. Perhaps the most frequently encountered problem is resistance to contracting in experienced therapists not explicitly training in this model. It is perceived as a significant break with previous training, and contrary to the traditions that underly the practice of longer-term therapy. Further, the tendency toward a too passive therapeutic posture with clients among inexperienced therapists is another source of diffusion of the crisis intervention process (Malan, 1976). Other inexperienced therapists find active engagement of the client threatening as it involves more direct participation in the therapeutic process. The therapist may also become the target of dysphoric affect that might be aroused and displaced to the therapist during crisis intervention. In fact, provoking anger or other negative affect is one of the techniques of crisis intervention (Brodsky, 1977).

The goals of the convergent model of crisis intervention are also different from other brief therapy models and long-term psychotherapy. The general goal of crisis intervention is to help the client to restore as quickly as possible the level of functioning that existed prior to the crisis rather than to effect a "cure." If an underlying conflict (precipitant) can be worked through during the crisis resolution process, that is an additional benefit to the client and will help reduce the probability of future, similar crises. At times, some therapists find it difficult to terminate clients in crisis therapy to return to daily life with unresolved problems not related to the present crisis situation. Yet, helping the client to regain the level of pre-crisis functioning remains the standard criterion against which success in crisis intervention is evaluated. In any service using crisis intervention as a therapeutic modality, it is understood that some clients will require referral for additional therapy or other services following crisis resolution.

The Effective Crisis Therapist

Therapists who are learning crisis intervention may experience varying levels of difficulty in adjusting to this model. Without systematic training in this approach, therapists tend to fall into the weaknesses of both the screening/assessment and the problem-solving approaches to crisis intervention. Therapists with strong traditional training may spend too much time doing an extensive and complete evaluation of the client prior to any "therapy"offered. This defeats the purpose of crisis intervention because most emotional crises are time-limited states and help must be quickly available if adaptive resolution is to occur. Other therapists who are novices or who are insecure in their therapeutic role often fail to provide structure and adopt a passive role in relation to the client. As a result, the crisis therapy spreads into other irrelevant problems, or turns exclusively to exploration of the past.

These therapist tendencies serve to diffuse the structure and focus required for effective crisis intervention. This diffusion of the crisis therapy process is compounded when clinic policies mandate short-term intervention and the therapist finds that the therapeutic process has become too involved to terminate at the appropriate time. The ability to create and maintain an effective time-goal contract in crisis intervention is a major determinant of outcome.

The well-trained crisis therapist is also able to use aspects of both the screening/assessment and problem-solving models with selected clients. For example, a choice might be made to use a screening/assessment approach when the therapist cannot continue to see a particular client through to crisis resolution (e.g.,vacations, not enough training to deal with a particular type of crisis,the crisis isn't appropriate for clinic services, etc.). Providing support and evaluating the client might also become the response of

choice when the presenting problem is a psychiatric and/or medical emergency and other treatment resources must be immediately mobilized.

At the other extreme are client crises that are primarily situationally determined. In such instances, the crisis therapist may elect to use the problem-solving style of crisis intervention to facilitate adaptive crisis resolution. This is a particularly useful model for intervention when there is no clear precipitant, when the locus of stress is primarily external to the individual (i.e., situational), and when the client had reasonably good pre-crisis levels of functioning.

In summary, the convergent model of crisis intervention is the basis for most crisis therapy. However, the evaluative approach of the screening/assessment model and the problem-solving approach of the alternate services are relevant for selected clients in the practice of crisis intervention. The well-trained crisis therapist is able to use all three models in clinical practice as appropriate to the needs of particular clients. However, the screening/assessment model and the problem-solving model for crisis intervention are incomplete approaches to crisis therapy when used exclusively.

Concluding Remarks

Crisis intervention is based on many of the principles of community mental health and preventive intervention (Silverman, 1977). Although originally conceptualized as a modality for primary prevention of mental illness (Lindemann, 1944), crisis intervention has now been demonstrated to be effective at both the secondary and tertiary levels of prevention. In fact, the majority of crisis intervention programs at present emphasize the secondary (rather than the primary) level of prevention.

The evolution of several quite distinct models for crisis intervention toward one convergent model has accelerated during this decade. One result

of this convergence has been modification of service delivery structures to optimize the effectiveness of this approach. For example, in clinical settings now structured to accommodate the screening/assessment model, opportunities to work with clients long enough for crisis resolution (in lieu of referral) are being provided. In other clinics, waiting lists are being eliminated or reduced to help crisis clients gain the accessibility necessary for adaptive resolution of time-limited crisis states.

The convergent model of crisis intervention is also being adopted by the alternate services that continue to provide community-based crisis counseling. In the alternate services that have begun to use the convergent model, creating structure and counselor attention to selected psychodynamics involved in the client's crisis (i.e., the precipitant) have now become more accepted practices. Such structure permits more counselor ability to guide and focus the therapeutic process in the direction of adaptive crisis resolution. Adoption of the tenets of the convergent model for crisis intervention has secondarily eased staff burn-out in the alternate services as well.

In the future, the convergence phenomenon in crisis intervention can be expected to continue. This has permitted the benefits of training in crisis intervention (Baldwin, 1977; Wales, 1972) to become more recognized and established as part of clinical training programs in the mental health professions. Further, this convergence has also been an impetus for continuing research into the theory and practice of crisis intervention as it evolves over time.

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Footnote

* Correspondence concerning this article should be sent to Bruce A Baldwin, Mental Health Division, Student Health Service, University of North Carolina, Chapel Hill, NC 27514.

Table Caption

Table 1. Overview of the major dimensions of two divergent styles of crisis intervention in relation to the convergent model.

		SCREENING/ASSESSMENT MODEL	CONVERGENT MODEL	PROBLEM-SOLVING MODEL
1.	Time Orientation	Past-Present	Past-Present-Future	Present-Future
2.	Assessment	Traditional Diagnostic	Crisis Assessment	Little Formal Assessment
3.	Response to Client Psychodynamics	Broad Spectrum	Focal Emphasis on Precipitant	Minimal Response
4.	Therapeutic Emphasis	Evaluation, Support, Emergency Services	Crisis Resolution	Present Problem-Solving
5.	Time Frame	1-2 Sessions	1-8 Sessions	Open-Ended
6.	Therapeutic Structure	Structured, Therapist Defined	Structured, Negotiated with Client	Relatively Unstructured
7.	Outcome Criteria	Referral Facilitated, Services Coordinated	Restoration of or Increase in Pre-Crisis Functioning	Problem-Resolved
8.	Common Problems	Little Treatment Beyond Client Support	Defining Time Frame/Relevant Goals, Maintaining Focal Emphasis	Dependency/Regression Issues, Therapist Over-Involvement
9.	Level of Training	Professional	Usually Professional	Usually Paraprofessional
10.	Typical Clinical Context	Emergency Rooms, Walk-In Clinics	Outpatient Clinics, CMHC's	Switchboards, Suicide Prevention Services

Note: Variations in these models for crisis intervention are recognized, but are conceptualized as above to clarify the dimensions on which they differ from one another.